The rarity of the case just recorded will become evident when I say that after a careful search through the literature of the last ten years I can find references to only 7 cases of ovarian cystoma complicated by appendicitis. That this must represent the greater number of cases which exist is almost certain. Even if the appendical trouble were overlooked, ovarian cystoma is so easily recognized and calls for such prompt operative treatment, that the double combination would be readily revealed. Of the 7 reported cases the greater number were cases of catarrhal or chronic appendicitis, and not perforative or suppurative. It is rather astonishing that appendical trouble is not more common with ovarian tumours than the published records suggest. One would have imagined that the same factors which predispose to appendicitis, and which exist in pregnancy, would have existed also in cystomata. It cannot be that many chronic conditions of the appendix are overlooked, because it has become almost a routine for the gynaecologist to examine the vermiform appendix even when operating for purely pelvic conditions.

In the case before us it would appear that the appendix contained a larger faecal concretion which had probably occupied the appendix for some considerable time without giving any evidence of its presence. As the ovarian tumour increased in size the intestines generally were pushed into the upper abdomen, and the appendix containing its hard concretion became directly exposed to the pressure of the neoplasm. The appendix lying in the iliac fossa became steadily compressed between the growth and the iliacus muscle. This eventually became so pronounced that the appendical wall became gangrenous and gave way at the point opposite to the concretion. In this almost purely mechanical way suppurative appendicitis probably arose.

It must at the outset be evident that, in the evacuation of an intraperitoneal abscess complicated by a large tumour, there is an increased risk of the supervention of general peritonitis. This is especially the case in suppurative appendicitis, where the organisms present, unlike those frequently met with in tubal infections, are almost always of the most virulent kind. The method adopted in the treatment of this case was, I feel satisfied, a sound one. It had for its justification three great objects in view: (1) To prevent fouling of the peritoneum during the complete evacuation of the abscess; (2) to efficiently drain the septic surface of the abscess; (3) to prevent for some days a spread of infection to the healthy peritoneal surface. It is for the third object that I specially commend the Mikulicz bag. Dr. Wilson and I have used it very extensively in our department both in oozing cavities and in extensively-fouled surfaces, with very great satisfaction. This method of draining those peritoneal abscesses in which the peritoneal cavity must be opened in order to reach them, whether pelvic, appendical, or upper abdominal, is, in my opinion, better than the introduction of one or more rubber tubes. The drainage is quite as efficient, and, most important of all, it retards the spread of infection to the virgin peritoneal surface by setting up an artificial barrier sufficiently secure to keep back germ invasion until peritoneal adhesions have had time to form. When such adhesions are established the immediate danger of general peritonitis is passed, and rubber tubes may then advantageously be substituted. This mode of surgical procedure is familiar enough, and is based upon scientific principles which are quite elementary. In the anxious moments, however, of dealing with these urgent abdominal conditions I fear that the systematic adoption of sound method is not always carried out—a fact which accounts for many unfavourable results. One always feels that in the treatment of ovarian, tubal, or appendical infections, where the peritoneal cavity must be extensively exposed, we are far too content to resign ourselves to the uncertainty of chance as to whether general peritonitis will supervene or not. I believe that in the method used in the above case we have one of the best means of obviating the necessity of trusting to chance and one which goes far to ensure success. The liver was primarily displaced by the upward pressure of the ovarian tumour, and later became anchored in this position to the chest wall by inflammatory adhesions induced by the appendicitis.

In conclusion, I would like to thank Dr. Faussett for the information he gave me concerning the case and for the assistance he rendered me during the operation.

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A NOTE ON THE THERAPEUTIC VALUE OF SARSAPARILLA IN SYPHILIS.

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In connexion with the interesting letter from Professor Clifford Allbutt in the British Medical Journal of March 24th on the value of sarsaparilla in syphilitic cachexia, I am sending what I have often thought I would publish, but never have published—a note of some observations I made when a student at Leeds, and afterwards when in charge of the medical wards as a resident officer at the Manchester Royal Infirmary. The observations had reference to the effect of sarsaparilla upon the body weight of syphilitic subjects. The preparation administered was that known at Leeds as syr. sarsae, which contained nothing but a decoction of sarsaparilla—prepared by boiling and reboiling, according to special directions*—and white sugar. Of this latter it never seemed to me there was enough either to render the preparation palatable or to justify the name of syrup. But that is a matter of opinion and does not affect the question. The dose of the syrup in all the cases here mentioned was 4 fluid oz. three times a day. The patients were on ordinary full diet unless the contrary is specified.

Case I.

J. W., aged 30, was admitted into the Leeds General Infirmary, August 8th, 1863, suffering from syphilitic cachexia. He was ordered syr. sarsae and no other medicine. His weight, not taken at first, was ascertained at the end of the first week and every week after that as long as he remained in the hospital, care being taken in this as in all the cases that the same clothes were worn on each occasion.

	st. lb.		lb.
Weight on Aug. 15th	... 7 1¾		
,, Aug. 22nd	... 7 7¾	; a gain in the week of	6
,, Aug. 29th	... 7 10¼	,, ,,	2½
,, Sept. 5th	... 8 2½	,, ,,	6¼
,, Sept. 12th	... 8 6½	,, ,,	4
,, Sept. 19th	... 8 11	,, ,,	4½
,, Sept. 26th	... 9 1¾	,, ,,	4¾
,, Oct. 4th	... 9 6	,, ,,	4¼

Total gain, 32¼ lb. in 7 weeks=a little more than 4½ lb. per week.

Case II.

W. K., aged 31, was admitted into the Leeds General Infirmary, September 18th, 1863, suffering from syphilitic cachexia. He was ordered syr. sarsae and no other medicine.

	st. lb.		lb.
Weight on Sept. 21st	... 8 11½		
,, Sept. 28th	... 9 1¾	; a gain in the week of	4¼
,, Oct. 5th	... 9 2¾	,, ,,	1
,, Oct. 12th	... 9 11	,, ,,	8¼
,, Oct. 19th	... 10 0	,, ,,	3

Total gain, 16½ lb. in 4 weeks = 4 lb. per week.

Case III.

J. E., aged 39, was admitted into the Leeds General Infirmary, June 5th, 1863, suffering from syphilis; pustules, sore throat, enlarged glands, hair falling off, pains in knee and shoulder, etc. On June 24th he was ordered syr. sarsae. On the 25th his weight was 7 st. 3½ lb. On July 31st he weighed 8 st. 6 lb., having gained 1 st. 2½ lb. in five weeks = 3 lb. per week.

Case IV.

W. T., aged 40, single, a stoker, was admitted into the Manchester Royal Infirmary under the care of Dr. Henry Simpson, January 30th, 1867. He had contracted syphilis some years previously, and was now suffering from cachexia with slight jaundice supposed to be from deposits in the liver. Mercurial ointment was ordered, and a few days later a mixture containing 5-gr. doses of potassium iodide. On March 7th, this was changed for a nitro-hydrochloric acid mixture. On March 16th, the weight (now taken for the first time) was 9 st. 13½ lb. A week later it was 9 st. 12 lb., showing a loss of 1½ lb. The syrup of sarsaparilla was now ordered, without other medicine.

	st. lb.		lb.
Weight on Mar. 30th	... 10 3¼	; a gain in the week of	5¼
,, April 6th	... 10 6¼	,, ,,	3
,, April 13th	... 10 9¾	,, ,,	3½
,, April 20th	... 10 8	; a loss in the week of	1¾

Average gain per week, whilst taking sarsaparilla only, 2½ lb.

* The directions were as follows: Put 3 lb. of sarsaparilla root into 2 gallons of water; boil down to 1 gallon and strain; add 2 gallons of water, boil down to 1 gallon, and strain; again add 2 gallons of water, boil down to 1 gallon, and strain; then add 2 lb. of sugar. The result will measure 3 gallons.

CASE V.

S. C., aged 22, single, a seamstress, was admitted into the Manchester Royal Infirmary under Dr. (afterwards Sir) William Roberts, July 22nd, 1867, suffering from what was then called syphilitic rheumatism. After a course of alkaline carbonates and potassium iodide, these were on August 7th discontinued and the syrup of sarsaparilla in full doses was substituted.

	st. lb.	lb.
Weight on Aug. 7th, 1867	... 6 2¾	
,, Aug. 14th ,,	... 6 7½	; a gain in the week of 4¾

On August 15th the patient left the hospital at her own request.

CASE VI.

J. P., aged 49, married, a fustian-cutter, was admitted into the Manchester Royal Infirmary under the care of Dr. H. Simpson, July 29th, 1867, suffering from syphilitic cachexia, with a livid papular eruption and evidences of chronic peritonitis. He was at first treated with iron, but on August 9th syr. sarsae was substituted for the iron. He was at that time taking a milk and beef-tea diet; this he continued until August 20th, when he was ordered an ordinary meat diet.

	st. lb.	Gain per Week.
Weight on Aug. 10th, 1867	... 6 8	
,, Aug. 17th ,,	... 6 12¼	... 4¼ lb. on sarsaparilla only
,, Aug. 24th ,,	... 7 2	... 2¾ lb. ,, ,,
,, Aug. 31st ,,	... 7 4¾	... 2¾ lb. ,, ,,
,, Sept. 7th ,,	... 7 6¼	... 1½ lb. ,, ,,

Total gain in four weeks. 12½ lb.=an average of a little over 3 lb. per week.

The greatest gain having been during the week when the patient was on a milk and beef-tea diet seems to show that the gain cannot entirely be accounted for by the diet.

CASE VII.

F. B., aged 25, married (but separated from her husband), a dressmaker, was admitted into the Manchester Royal Infirmary under Dr. T. H. Watts, February 3rd, 1868, suffering from syphilitic cachexia with periosteal symptoms. On her admission she was ordered a mixture containing 5-gr. doses of potassium iodide. On March 11th, syr. sarsae was substituted for this, but on the 19th, for some reason not stated in my notes, the sarsaparilla was discontinued and the potassium iodide resumed.

	st. lb.	lb.
Weight on Feb. 14th	... 6 13½	
,, Feb. 21st	... 7 3	; a gain in the week of 3½

CASE VIII.

W. M., aged 29, single, a collier, was admitted into the Manchester Royal Infirmary, under the care of Dr. T. H. Watts, February 10th, 1868, suffering from syphilitic ulceration of the pharynx, said to be of five months' duration. On February 12th he was ordered syr. sarsae, 4 fluid oz., three times a day, without other medicine.

	st. lb.	lb.
Weight on Feb. 13th	... 8 6½	
,, Feb. 20th	... 8 9	; a gain in the week of 2½

CASE IX.

J. D., aged 25, a widower, by occupation a wheelwright, was admitted into the Manchester Royal Infirmary under the care of Dr. T. H. Watts, March 6th, 1868, suffering from large painful swellings along the front of both tibiae and caries of the bones of the nose. He was ordered potassium iodide in doses of 5 gr., the quantity to be gradually increased. On March 28th he was taking 35 gr. per diem. On April 4th he was taking 45 gr. daily. He was now ordered syr. sarsae in addition, and continued to take it until April 25th.

	st. lb.	Gain per Week.
Weight on April 4th, 1868	...8 1	
,, April 11th ,,	...8 7¾	... 6¾ lb. on pot. iod. and sarsap.
,, April 18th ,,	...8 12¼	... 4½ lb. ,, ,, ,,
,, April 25th ,,	...9 0¾	... 2½ lb. ,, ,, ,,
,, May 2nd ,,	...9 3	... 2¼ lb. on pot. iod. without sarsap.
,, May 9th ,,	...9 4¼	... 1¼ lb. ,, ,, ,,

On May 11th he became an out-patient. For two weeks he was, owing to an oversight, entirely without medicine. On May 23rd he was ordered 10-gr. doses of pot. iodid. with iron.

	st. lb.		lb.
Weight on May 16th	... 9 3¼	; a loss in the week of	0¾
,, May 23rd	... 9 3¾	gain ,,	0½
,, June 2nd	... 9 3	loss ,,	0¾
,, June 9th	... 9 5¾	gain ,,	2¾
,, June 16th	... 9 6½	,, ,,	0¾
,, June 30th	... 9 7	gain in 2 weeks of	0½

The following and last case is one in which improvement was greater when treated with potass. iodid. alone than when treated with sarsaparilla alone:

CASE X.

M. J., aged 27, married, was admitted into the Manchester Royal Infirmary, under the care of Dr. (afterwards Sir) William Roberts, April 17th, 1868, suffering from a syphilitic ulceration at the os uteri and at the posterior commissure of the vulva, a livid scaly eruption, intense headache, with tenderness of scalp (the pain being worse at night), and slight delirium. The potassium iodide ordered on admission was supplemented on April 25th by 4 fluid oz. of syr. sarsae, three times a day. On May 1st the sarsaparilla began to be given alone, but on the 7th it was for some reason discontinued, and the potass. iodid. resumed.

	st. lb.	
Weight on April 17th, 1868	... 7 1¼	
,, ,, 24th, ,,	... 7 3¼	; gain, 2 lb. (pot. iod.)
,, May 1st ,,	... 7 6	; gain. 2¾ lb. (pot. iod. and sarsap.)
,, ,, 8th ,,	... 7 6¾	; gain, 0¾ lb. (sarsap. only)
,, ,, 15th ,,	... 7 10	; gain, 3¼ lb. (pot. iod. only)
,, ,, 22nd ,,	... 7 12	; gain, 2 lb. (pot. iod. only)

I realize that these notes are not full enough or numerous enough to be of any very great value, but few and scanty as they are, they seem to me to be worth placing on record. The Manchester series of observations was watched at the time with considerable interest, not unmixed with a wholesome scientific scepticism, both by the resident and visiting staff. Those of my readers who are familiar with the atmosphere of a hospital common-room will well understand this. Nowhere have doubtful questions and "tall" stories to bear the brunt of a more unmerciful scrutiny, and this Leeds story of mine had to share the usual fate. I have had no opportunity since of following up these observations save in the most desultory manner. But I was pleased to know that sarsaparilla still holds its own at Leeds. I was also glad to be reminded that the credit of introducing the preparation at the Leeds Infirmary was due to that fine old surgeon (who was also lecturer on midwifery), Samuel Smith, in whose praise Professor Allbutt says not one word too much.

The Lumleian Lectures

ON

TABES DORSALIS.

DELIVERED BEFORE THE ROYAL COLLEGE OF PHYSICIANS

BY DAVID FERRIER, M.D., F.R.S.,

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LECTURE II.*

IN health the centrifugalized deposit from the cerebro-spinal fluid contains scarcely any cellular elements beyond an occasional endothelial cell and perhaps one to three lymphocytes in a field with a magnification of 400 diameters.

In certain diseases the cellular elements are present in excess. In acute microbic affections of the cerebro-spinal meninges, as by staphylococcus, pneumococcus, and *Diplococcus intracellularis*, a leucocytosis occurs, in which the leucocytes are of the polynuclear type. On the other hand, in certain chronic affections of the meninges, syphilitic, tuberculous, etc., an excess of leucocytes also occurs. These are of the mononuclear type; in other words, there is a lymphocytosis. It has been shown by Widal, Sicard, Ravaut, and others—and their observations have been confirmed by my own and Purves Stewart's investigations—that in tabes, as well as in general paralysis of the insane, from the earliest to the latest stages there is a marked lymphocytosis of the cerebro-spinal fluid. I have in several instances relied on this lymphocytosis as establishing the diagnosis of general paralysis before there were any abnormalities of the pupils or other physical signs characteristic of the disease. In a case of tabes or general paralysis, instead of two or three, as in the normal state, one may count a hundred, or even several hundred, lymphocytes in the field of the microscope. At first sight this lymphocytosis would seem to confirm the views of those who ascribe the disease to a syphilitic affection of the meninges, either generally, or of Nageotte's meningeal root sheath, or of the posterior lymphatic system of the spinal cord as maintained by Marie and Guillain. But lymphocytosis occurs in other affections in which meningitis, syphilitic or otherwise, plays no part. Thus it has been found in Landry's paralysis, in the sub-acute combined degeneration of pernicious anaemia (Purves Stewart), and in herpes zoster (Sicard). Lymphocytosis cannot therefore be regarded as pathognomonic of meningeal inflammation, though no doubt meningeal inflammation would accentuate it. But the most powerful argument against the syphilo-meningeal origin of the

* The lecture was illustrated by lantern slides.